EULAR recommendations for the use of imaging in the diagnosis and management of spondyloarthritis in clinical practice

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ABSTRACT
A taskforce comprised of an expert group of 21 rheumatologists, radiologists and methodologists from 11 countries developed evidence-based recommendations on the use of imaging in the clinical management of both axial and peripheral spondyloarthritis (SpA). Twelve key questions on the role of imaging in SpA were generated using a process of discussion and consensus. Imaging modalities included conventional radiography, ultrasonography, magnetic resonance imaging, computed tomography (CT), positron emission tomography, single photon emission CT, dual-emission x-ray absorptiometry and scintigraphy. Experts applied research evidence obtained from systematic literature reviews using MEDLINE and EMBASE to develop a set of 10 recommendations. The strength of recommendations (SOR) was assessed by taskforce members using a visual analogue scale. A total of 7550 references were identified in the search process, from which 158 studies were included in the systematic review. Ten recommendations were produced using research-based evidence and expert opinion encompassing the role of imaging in making a diagnosis of axial SpA or peripheral SpA, monitoring inflammation and damage, predicting outcome, response to treatment, and detecting spinal fractures and osteoporosis. The SOR for each recommendation was generally very high (range 8.9–9.5). These are the first recommendations which encompass the entire spectrum of SpA and evaluate the full role of all commonly used imaging modalities. We aimed to produce recommendations that are practical and valuable in daily practice for rheumatologists, radiologists and general practitioners.

The group of spondyloarthritides comprises a number of closely related rheumatic diseases with common clinical features,1 including ankylosing spondylitis (AS), psoriatic arthritis (PsA), arthritis/ spondylitis related to inflammatory bowel disease and reactive arthritis (ReA).3–6
In addition to these subtypes, patients with spondyloarthritis (SpA) can also be grouped into two categories based on their predominant clinical presentation: axial and peripheral.1–2 This division was reflected in the Assessment of SpondyloArthritis International Society (ASAS) classification criteria, which separated axial and peripheral SpA (axSpA and pSpA).7–8 Imaging is a key component of classification criteria for SpA, primarily due to the lack of specific clinical symptoms as well as varying disease activity over time. For example, radiographic sacroiliitis is an essential part of the internationally accepted modified New York criteria for AS.4 Significant advances have been made within the field of imaging in SpA over the past decade. Several imaging modalities are now available that may aid in the diagnosis and monitoring of both axSpA and pSpA as well as in predicting structural damage and treatment response. However, conventional radiography (radiography) only visualises the late structural consequences of the inflammatory process, while the early inflammatory changes can be detected by MRI, often several years before the appearance of sacroiliitis on radiography.9 Accordingly, MRI was incorporated in the ASAS classification criteria for axSpA as well as pSpA.7–8
Reflecting the perceived need for developing evidence-based recommendations on the use of musculoskeletal imaging in the clinical management of SpA, a European League Against Rheumatism (EULAR) taskforce was convened to develop evidence-based recommendations on the use of musculoskeletal imaging in the clinical management of SpA, for rheumatologists, radiologists and general practitioners.

METHODS
An expert group of 21 rheumatologists, radiologists and methodologists representing 11 countries formed the taskforce. The objectives were to formulate key clinical questions relating to the role of imaging in SpA, to identify and critically appraise the available evidence, and to generate recommendations based on both evidence and expert opinion.
At the initial taskforce meeting, members proposed clinically relevant questions related to key aspects of the use of imaging in SpA. Twelve final research questions (Q1–12) were formulated and agreed upon by consensus, encompassing the full spectrum of the role of imaging in diagnosingaxSpA or pSpA, monitoring inflammation and damage, predicting outcome and response to treatment, as well as detecting spinal fractures and

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osteoporosis (see online supplementary material S1: research questions).

Three systematic literature searches were performed using MEDLINE and EMBASE databases. The first search summarised research questions 1–10 (Q1–10) (questions on the diagnostic, monitoring and predictive role of imaging), while the research question on the detection of spinal fractures (Q11) and that on the detection of osteoporosis (Q12) were covered by independent searches. Specific medical subject headings and additional keywords were used to identify all relevant studies (see online supplementary material S2: search strategy). In addition, abstract archives of relevant international rheumatology and radiology meetings (2011, 2012) as well as the bibliographies of included papers were hand searched for evidence of other studies for inclusion. Titles and abstracts of all citations identified were screened, and potentially relevant articles were reviewed in full text using predetermined inclusion and exclusion criteria.

Studies published in English up to January 2013, on the use of imaging in adults (≥18 years) with a suspected or established clinical diagnosis of SpA (including inflammatory and low back pain for the research question on the diagnostic role of imaging in axSpA, axSpA or pSpA (and suspicion of spinal (vertebral)) fracture with regard to Q11), were included. Imaging modalities included radiography, ultrasound (US), MRI, CT, positron emission tomography, single-photon emission CT (SPECT), quantitative sacroiliac (SI) joint scintigraphy (QSS) and dual-energy X-ray absorptiometry (DXA). Study types included randomised controlled trials (RCTs), systematic reviews, controlled clinical trials, cohort, case-control and diagnostic studies.

Studies not in English language, those including patients ≤18 years of age and those reporting data acquired from <20 patients with suspected or established disease (and/or <20 control patients for questions 1–2 on the diagnostic role of imaging) were excluded. Quality assessment of all included studies was done using the QUADAS-2 tool10 and presented graphically for each research question.11

Data from the literature reviews were categorised and presented at the second taskforce meeting according to study design using a hierarchy of evidence in descending order according to quality.12 The literature review was conducted by PM, VNC and PB. Data extraction for each research question was reviewed by at least two of the above-mentioned taskforce members. Greater emphasis was given to the best available evidence, although all data were collected and reviewed. Expert evidence was cited only when available research evidence was lacking. The experts finally formulated 10 recommendations based on the 12 clinical questions through a process of discussion and consensus, followed by final wording adjustments by email exchange. The finally perceived strength of recommendation (SOR) for each proposition was scored by the experts using a 0–10 visual analogue scale (VAS; 0=not recommended at all, 10=fully recommended) with data from the quality assessment. Scores reflected both research evidence and clinical expertise.13

A research agenda was agreed upon by consensus following the presentation of the literature reviews.

**RESULTS**

The combined search for Q1–12 resulted in a total of 7550 records, of which a total of 138 articles were finally selected for inclusion in the systematic literature review. Articles that were relevant to >1 research question were included in the review more than once. The flow charts showing the detailed results of all three searches are shown in online supplementary figure S3. The number of articles included for each research question is shown in online supplementary table S4. Taskforce members produced 10 recommendations based on a process of discussion. The recommendations, SOR (mean VAS and 95% CI) and level of evidence are presented in table 1. A full reference list for articles included in each recommendation is shown in online supplementary material S5.

**Recommendations**

**Recommendation 1: diagnosing axial SpA**

A. In general, conventional radiography of the SI joints is recommended as the first imaging method to diagnose sacroiliitis as part of axial SpA. In certain cases, such as young patients and those with short symptom duration, MRI of the SI joints is an alternative first imaging method.

B. If the diagnosis of axial SpA cannot be established based on clinical features and conventional radiography, and axial SpA is still suspected, MRI of the SI joints is recommended. On MRI, both active inflammatory lesions (primarily bone marrow oedema (BME)) and structural lesions (such as bone erosion, new bone formation, sclerosis and fat infiltration) should be considered. MRI of the spine is not generally recommended to diagnose axial SpA.

C. Imaging modalities other than conventional radiography and MRI are not generally recommended in the diagnosis of axial SpA.

*CT may provide additional information on structural damage if conventional radiography is negative and MRI cannot be performed. Scintigraphy and US are not recommended for diagnosis of sacroiliitis as part of axial SpA.

Strength of recommendation: 9.5 (95% CI 9.2 to 9.8).

Twenty-five studies evaluated the diagnostic utility of various imaging modalities in axSpA.14–38 Five studies reported on the diagnostic utility of radiography.14–18 They demonstrated varying sensitivity (SE) and specificity (SP) of radiography in diagnosing sacroiliitis in inflammatory back pain (IBP)/suspicion of SpA, while one observational study reported an SE of 0.84 and an SP of 0.75 in diagnosing sacroiliitis in AS.14–18 A single study reported only fair agreement between radiography and CT in suspected sacroiliitis and many false positive results using radiography.18 Two studies reported higher SE for CT than radiography for diagnosing sacroiliitis (1 in AS, 1 in suspected SpA).15 17

Thirteen studies evaluated the diagnostic utility of MRI demonstrating varying SE and overall higher SP in patients with IBP or those with suspicion of SpA (table 2).19–31 Three studies reported SE (0.73–0.9) and SP (0.9–0.97) for SI joint BME on MRI in established AS.22 23 25 Wick et al36 reported an SE of 0.11 and an SP of 0.93 for MRI SI joint erosions for diagnosis of AS, while Weber et al25 reported that the combined features of SI joint erosion and/or BME increased SE to 0.98–0.96 compared with BME alone (0.91–0.83) without reducing SP and the area under the curve for diagnosis of AS. Heuft-Dorenbosch et al found that initial assessment of structural changes by radiography followed by MRI assessment of inflammation with negative radiography gives the highest returns for detecting involvement of the SI joint in patients with recent IBP.27 Finally, two studies found MRI of the SI joint superior to QSS or radiography for diagnosing sacroilitis in IBP and SpA.14 33

With regard to MRI of the spine, three studies reported SE of and SP for corner fat lesions and corner inflammatory lesions (CILs) in patients suspected for axSpA29 30 31 while two studies reported SE and SP in established AS.31 32 Finally, Weber et al25 have demonstrated that spinal MRI adds little incremental value...
compared with MRI of the SI joint alone in terms of lesion detection and classification of patients with early SpA. Four studies reported that QSS has low SE for diagnosis of sacroiliitis in patients with IBP and AS. One study reported that contrast-enhanced US detects sacroiliitis in patients with AS. Quality assessment is reported in online supplementary figure S6.1; of note risk of patient selection bias and applicability concerns with regard to patient selection were high in 52% and 36% of the included manuscripts, respectively.

**Recommendation 2: diagnosing peripheral SpA**

When peripheral SpA is suspected, US or MRI may be used to detect peripheral enthesitis, which may support the diagnosis of SpA. Furthermore, US or MRI might be used to detect peripheral arthritis, tenosynovitis and bursitis.

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**Table 1** EULAR recommendations for the use of imaging in the diagnosis and management of spondyloarthritis in clinical practice

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>SOR</th>
<th>LOE</th>
</tr>
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<tbody>
<tr>
<td>1 Axial SpA: diagnosis</td>
<td>9.5 (9.2–9.8)</td>
<td>III</td>
</tr>
<tr>
<td><strong>A.</strong> In general, conventional radiography of the SI joints is recommended as the first imaging method to diagnose sacroiliitis as part of axial SpA.</td>
<td></td>
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<tr>
<td><strong>B.</strong> In some cases, such as young patients and those with shorter symptom duration, MRI of the SI joints is an alternative first imaging method.</td>
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<tr>
<td><strong>C.</strong> US or MRI should be used to confirm clinical suspicion of SpA.</td>
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<tr>
<td>2 Peripheral SpA: diagnosis</td>
<td>9.4 (9.0–9.8)</td>
<td>III</td>
</tr>
<tr>
<td><strong>When peripheral SpA is suspected, US or MRI may be used to detect peripheral enthesitis, which may support the diagnosis of SpA.</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>3 Axial SpA: monitoring activity</td>
<td>9.2 (8.8–9.6)</td>
<td>Ib</td>
</tr>
<tr>
<td><strong>MRI of the SI joints and/or the spine may be used to assess and monitor disease activity in axial SpA, providing additional information on top of clinical and biochemical assessments. The decision on when to repeat MRI depends on the clinical circumstances. In general, STIR sequences are sufficient to detect inflammation and the use of contrast medium is not needed.</strong></td>
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<tr>
<td>4 Axial SpA: monitoring structural changes</td>
<td>9.3 (8.8–9.8)</td>
<td>Ib</td>
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<tr>
<td><strong>Conventional radiography of the SI joints and/or spine may be used for long-term monitoring of structural damage, particularly new bone formation, in axial SpA. If performed, it should not be repeated more frequently than every second year. MRI may provide additional information.</strong></td>
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<tr>
<td>5 Peripheral SpA: monitoring activity</td>
<td>9.3 (8.9–9.7)</td>
<td>Ib</td>
</tr>
<tr>
<td><strong>US and MRI may be used to monitor disease activity (particularly synovitis and enthesitis) in peripheral SpA, providing additional information on top of clinical and biochemical assessments.</strong></td>
<td></td>
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<tr>
<td>6 Peripheral SpA: monitoring structural changes</td>
<td>8.9 (8.4–9.4)</td>
<td>III</td>
</tr>
<tr>
<td><strong>In peripheral SpA, if the clinical scenario requires monitoring of structural damage, then conventional radiography is recommended. MRI and/or US might provide additional information.</strong></td>
<td></td>
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<tr>
<td>7 Axial SpA: predicting outcomes/severity</td>
<td>9.0 (8.5–9.5)</td>
<td>Ib</td>
</tr>
<tr>
<td><strong>In patients with ankylosing spondylitis (not non-radiographic axial SpA), initial conventional radiography of the lumbar and cervical spine is recommended to detect syndesmophytes, which are predictive of development of new syndesmophytes. MRI (vertebral corner inflammatory or fatty lesions) may also be used to predict development of new radiographic syndesmophytes.</strong></td>
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<tr>
<td>8 Axial SpA: predicting treatment effect</td>
<td>8.9 (8.3–9.5)</td>
<td>Ib</td>
</tr>
<tr>
<td><strong>Extensive MRI inflammatory activity (bone marrow oedema), particularly in the spine in patients with ankylosing spondylitis, might be used as a predictor of good clinical response to anti-TNF-alpha treatment in axial SpA.</strong></td>
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<tr>
<td>9 Spinal fracture</td>
<td>9.3 (8.9–9.7)</td>
<td>IV</td>
</tr>
<tr>
<td><strong>When spinal fracture in axial SpA is suspected, conventional radiography is the recommended initial imaging method.</strong></td>
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<tr>
<td>10 Osteoporosis</td>
<td>9.4 (9.0–9.8)</td>
<td>III</td>
</tr>
<tr>
<td><strong>In patients with axial SpA without syndesmophytes in the lumbar spine on conventional radiography, osteoporosis should be assessed by hip DXA and AP-spine DXA. In patients with syndesmophytes in the lumbar spine on conventional radiography, osteoporosis should be assessed by hip DXA, supplemented by either spine DXA in lateral projection or possibly QCT of the spine.</strong></td>
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</table>

*CT may provide additional information on structural damage if conventional radiography is negative and MRI cannot be performed. Scintigraphy and US are not recommended for diagnosis of sacroiliitis as part of axial SpA.*

**That is, radiographic axial spondyloarthritis.**

**Level of evidence (LOE): Ia, evidence for meta-analysis of randomised controlled trials; Ib, evidence from at least one randomised controlled trial; Iia, evidence from at least one controlled study without randomisation; Iib, evidence from at least one other type of quasi-experimental study; III, evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case–control studies; IV, evidence from expert committee reports or opinions or clinical experience of respected authorities, or both. AP, anterior-posterior; CRP, C-reactive protein; DXA, dual-energy X-ray absorptiometry; EULAR, European League Against Rheumatism; m-spondylo, non-radiographic axial spondyloarthritis; O/I/CT, quantitative CT; SI, sacroiliac; SI, sacroiliac joints; SOR, strength of recommendation; SpA, spondyloarthritis; STIR, short tau inversion recovery; T1-weighted, T2-weighted, and T2*‐weighted images; T1-weighted and T2-weighted images; T2-weighted and T2*‐weighted images.**

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Quality assessment is reported in online supplementary figure S6.2; of note risk of patient selection bias and applicability concerns with regard to the index test were high in 55% and 33% of included manuscripts, respectively.

**Recommendation 3: monitoring disease activity in axial SpA**

MRI of the SI joints and/or the spine may be used to assess and monitor disease activity in axial SpA, providing additional information on top of clinical and biochemical assessments. The decision on when to repeat MRI depends on the clinical circumstances. In general, short tau inversion recovery (STIR) sequences are sufficient to detect inflammation and the use of contrast medium is not needed.

**Strength of recommendation:** 9.2 (95% CI 8.8 to 9.6)

Thirty-four studies evaluated the utility of MRI in monitoring disease activity in axSpA. 20 21 48–79 Table 3 summarises and presents the results of longitudinal 20 21 22 50–54 61 63 64 66–69 71 73 74 75 as well as cross-sectional 51 59 60 70 79, 80–97 studies evaluating correlation with accepted disease activity parameters (Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Ankylosing Spondylitis Disease Activity Score (ASDAS), C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)) or pain.

In addition, seven studies compared the utility of different MRI sequences (contrast-enhanced T1-weighted (T1Gd) and STIR) for monitoring disease activity in axial SpA, 48 49 53–56, 57 65–72 six of which reported high levels of agreement or correlation between the two sequences. 48 49 53–56, 57 65–72 A single longitudinal and two cross-sectional studies reported higher SE of STIR, 49 53 66 while a single longitudinal and two cross-sectional studies reported higher diagnostic confidence/reliability of the T1Gd-DPTA sequence. 48 49 53

Regarding frequency of spinal MRI examination, two longitudinal and two cross-sectional studies reported significant changes detected already at 6 or 12 weeks. 50 72 with similar results for both STIR and T1Gd sequences. 72 There is currently no evidence for how frequently MRI should be repeated for monitoring disease activity in axial SpA. Quality assessment is reported in online supplementary figure S6.3.

**Recommendation 4: monitoring structural changes in axial SpA**

Conventional radiography of the SI joints and/or spine may be used for long-term monitoring of structural damage, particularly new bone formation, in axial SpA. If performed, it should not be repeated more frequently than every second year. MRI may provide additional information.

**Strength of recommendation:** 9.3 (95% CI 8.8 to 9.8)

Twenty-three studies evaluated the utility of various imaging modalities in monitoring structural damage in axSpA. 50 63 70–72 80–97 Of 13 radiography studies, 10 reported correlation between radiographic changes and accepted measures of function (Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Metrology Index (RASMI), metrological measures (chest expansion, occiput-to-wall distance, finger-to-floor distance, trunk-to-wall distance, Schober’s test, spinal flexion, cervical rotation)) (table 4). 63 81–83 85–87 93 94 96

Six studies compared various spine radiography scoring methods (Bath Ankylosing Spondylitis Radiology Index (BASRI), Stoke Ankylosing Spondylitis Spinal Score (SASSS), modified Stoke Ankylosing Spondylitis Spinal Score (mSASSS), Berlin X-ray score, Radiographic Ankylosing Spondylitis Spinal Score (RASSS)), 83 94 87 92 93 96 of which two reported mSASSS being superior to BASRI and SASSS. 94 95 Baraliakos et al 96 reported the RASSS method, which includes the thoracic segment, superior to mSASSS, while Ramiro et al 97 reported no advantage of RASSS over mSASSS. Taylor et al 98 reported correlation between CT changes and QSS in the SI joint.

### Table 2 Recommendation 1: summary of studies on the use of MRI in diagnosing axial spondyloarthritis

<table>
<thead>
<tr>
<th>Studies</th>
<th>No.</th>
<th>Study population</th>
<th>Gold standard</th>
<th>SIJ/spine</th>
<th>MRI lesion</th>
<th>SE</th>
<th>SP</th>
<th>+LR</th>
<th>−LR</th>
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<tbody>
<tr>
<td>Longitudinal/RCT</td>
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<tr>
<td>Bennett et al 72</td>
<td>50</td>
<td>SpA</td>
<td>X-ray</td>
<td>SIJ</td>
<td>Grade 3 SI+HLAB27 27B27</td>
<td>0.62</td>
<td>0.92</td>
<td>7.7</td>
<td>0.41</td>
</tr>
<tr>
<td>Marzo-Ortega et al 80</td>
<td>76</td>
<td>IBP (NSBP, HC)</td>
<td>Clinical diagnosis</td>
<td>SIJ</td>
<td>Grade 1 SI</td>
<td>0.82</td>
<td>0.43</td>
<td>1.4</td>
<td>0.41</td>
</tr>
<tr>
<td>Oostveen et al 91</td>
<td>25</td>
<td>IBP</td>
<td>X-ray</td>
<td>SIJ</td>
<td>Grade ≥ 2 SI</td>
<td>0.85</td>
<td>0.47</td>
<td>1.6</td>
<td>0.31</td>
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<tr>
<td>Cross-sectional/case-control</td>
<td></td>
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<tr>
<td>Weber et al 82 83</td>
<td>187</td>
<td>AS, IBP (NSBP, HC)</td>
<td>Clinical diagnosis</td>
<td>SIJ</td>
<td>BME (AS)</td>
<td>0.9</td>
<td>0.97</td>
<td>44.4</td>
<td>0.92</td>
</tr>
<tr>
<td>Weber et al 84 85</td>
<td>157</td>
<td>AS, IBP (NSBP, HC)</td>
<td>Clinical diagnosis</td>
<td>SIJ</td>
<td>BME</td>
<td>0.73</td>
<td>0.9</td>
<td>7.3</td>
<td>0.23</td>
</tr>
<tr>
<td>Heuft-Dorenbosch et al 86</td>
<td>68</td>
<td>IBP</td>
<td>X-ray</td>
<td>SIJ</td>
<td>chronic changes</td>
<td>0.49</td>
<td>0.97</td>
<td>16.3</td>
<td>0.52</td>
</tr>
<tr>
<td>Weber et al 87</td>
<td>95</td>
<td>AS, IBP, (HC)</td>
<td>Clinical diagnosis</td>
<td>Spine</td>
<td>&gt;2 CIL (AS)</td>
<td>0.69</td>
<td>0.94</td>
<td>12</td>
<td>0.32</td>
</tr>
<tr>
<td>Kim et al 90</td>
<td>104</td>
<td>AS (HC)</td>
<td>Clinical diagnosis</td>
<td>Spine</td>
<td>MRI corner sign</td>
<td>0.44</td>
<td>0.96</td>
<td>11</td>
<td>0.58</td>
</tr>
<tr>
<td>Retrospective</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Wick et al 91</td>
<td>179</td>
<td>AS (various)</td>
<td>Clinical diagnosis</td>
<td>SIJ</td>
<td>ERO</td>
<td>0.11</td>
<td>0.93</td>
<td>1.57</td>
<td>0.95</td>
</tr>
<tr>
<td>Bennett et al 92 93</td>
<td>185</td>
<td>SpA (DA, IBP, HC)</td>
<td>Clinical diagnosis</td>
<td>SIJ and spine</td>
<td>&gt;3 RLs</td>
<td>0.33</td>
<td>0.99</td>
<td>14.5</td>
<td>0.87</td>
</tr>
</tbody>
</table>

The terms of the individual original publications have been used in the table.

AS, ankylosing spondylitis; BME, bone marrow oedema; CIL, corner inflammatory lesion; DA, degenerative arthropathy; ERO, erosion; FL, fatty infiltration; FRL, fatty Romanus’ lesion; HC, healthy control; HLAB27, human leucocyte antigen B27; IBP, inflammatory back pain; LIL, lateral segment inflammatory lesion; +LR, positive likelihood ratio; −LR, negative likelihood ratio; No., number of individuals included in the study; NSBP, non-specific back pain; RCT, randomised controlled trial; RL, ‘Romanus’ lesion; SE, sensitivity; SP, specificity; SI, sacroiliitis; SIJ, sacroiliac joints; SpA, spondyloarthritis.
Five studies reported correlation between changes over time in MRI and radiography and/or CT parameters of structural damage,\(^7,9,14,88,90\) while Puhakka et al.\(^{91}\) found MRI and CT are superior to radiography. A single study reported correlation between spinal MRI and metrological measures,\(^9\) while two reported no correlation.\(^7,9\) One study reported correlation between MRI changes and BASMI,\(^88\) whereas two studies reported no correlation with BASFI.\(^70,97\) Akgul et al.\(^91\) reported that fatty infiltration of the paraspinal muscles on MRI correlates with metrological measures. Regarding the frequency of MRI examinations for the monitoring of structural changes under treatment with a tumour necrosis factor (TNF) inhibitor, Rudwaleit et al.\(^74\) reported no significant spinal or SI joint changes after 24 weeks, while Baraliakos et al. reported significant deterioration in the mean Ankylosing Spondylitis spinal MRI chronicity score (ASsMRI-c) in the placebo group at 48 weeks.\(^50\) There is currently no evidence whether and if so how frequently MRI should be repeated for the monitoring of structural changes in axial SpA. Quality assessment is reported in online supplementary figure S6;4; of note risk of patient selection bias and applicability concerns with regard to patient selection were high in 43% and 30% of included manuscripts, respectively.

**Recommendation 5:** monitoring disease activity in peripheral SpA

US and MRI may be used to monitor disease activity (particularly synovitis and enthesitis) in peripheral SpA, providing additional information on top of clinical and biochemical assessments. The decision on when to repeat US/MRI depends on the clinical circumstances. US with high-sensitivity colour or power Doppler is sufficient to detect inflammation and the use of US contrast medium is not needed.

**Strength of recommendation:** 9.3 (95% CI 8.9 to 9.7)

Fifteen studies evaluated the utility of various imaging modalities in monitoring disease activity in pSpA,\(^39,40,98,110,133\) of which 10 investigated GSUS/PDUS for the assessment of entheses (8 on multiple entheses, 2 on the Achilles tendon). Out of the 10 studies investigating GSUS/PDUS, only a single study was longitudinal,\(^98\) while the remaining 9 were cross-sectional.\(^39,40,98,105\) A single study reported correlation with BASDAI,\(^95\) while four reported no correlation.\(^98,100,102,105\) Aydin et al.\(^100\) reported correlation between grey-scale enthesal changes of the Achilles tendon and CRP while five studies reported no correlation with CRP and/or ESR.\(^98,101,104\) Hamdi et al.\(^99\) reported correlation between pain and power Doppler enthesal changes of the lower limb entheses, while Kiris et al.\(^102\) reported no correlation between PD and axial entheses.

Two studies reported correlation with swollen or tender joint count,\(^39,104\) while a single study reported no correlation.\(^40\) Hamdi et al.\(^99\) reported correlation with clinical enthesis indices (Maastricht Ankylosing Spondylitis Score, Spondyloarthritis Research Consortium of Canada (SPARCC) Enthesitis Index), while two studies reported no correlation.\(^39,98\) Two studies reported discrepancies in abnormal entheses detected by US versus clinical examination.\(^40,105\)

### Table 3: recommendation 3: summary of studies on the use of MRI in monitoring disease activity in axial spondyloarthritis

<table>
<thead>
<tr>
<th>Studies</th>
<th>No.</th>
<th>Region</th>
<th>MRI scoring method</th>
<th>Correlation</th>
<th>ASDAS</th>
<th>BASDAI</th>
<th>CRP</th>
<th>ESR</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longitudinal/RCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marzo-Ortega et al.(^{20})</td>
<td>76</td>
<td>Spine</td>
<td>LEEDS</td>
<td>–</td>
<td>NS</td>
<td>NS</td>
<td>–</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Oostveen et al.(^{21})</td>
<td>25</td>
<td>SJ</td>
<td>mNY</td>
<td>–</td>
<td>NS</td>
<td>OR 2.1</td>
<td>OR 2.1</td>
<td>OR 1.2</td>
<td></td>
</tr>
<tr>
<td>Baraliakos et al.(^{40})</td>
<td>40</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>–</td>
<td>NS</td>
<td>NS</td>
<td>–</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Bonel et al.(^{12})</td>
<td>28</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>0.41</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Braun et al.(^{53})</td>
<td>20</td>
<td>Spine</td>
<td>ASsMRI-a/c</td>
<td>0.49–0.6</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Braun et al.(^{54})</td>
<td>98</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>0.35</td>
<td>NS</td>
<td>0.4</td>
<td>–</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Lambert 2007(^{41})</td>
<td>82</td>
<td>Spine/SJ</td>
<td>SPARCC</td>
<td>–</td>
<td>NS</td>
<td>p=0.018</td>
<td>–</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Machado et al.(^{13})</td>
<td>221</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>0.14</td>
<td>NS</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machado et al.(^{54})</td>
<td>221</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>0.23</td>
<td>NS</td>
<td>0.32</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maksymowych et al.(^{56})</td>
<td>68</td>
<td>Spine</td>
<td>SPARCC</td>
<td>–</td>
<td>NS</td>
<td>0.65–0.68</td>
<td>–</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Maksymowych et al.(^{57})</td>
<td>36</td>
<td>Spine</td>
<td>SPARCC</td>
<td>–</td>
<td>NS</td>
<td>0.45</td>
<td>0.44</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Marzo-Ortega et al.(^{48})</td>
<td>42</td>
<td>Spine/SJ</td>
<td>LEEDS</td>
<td>p=0.04</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<td></td>
</tr>
<tr>
<td>Pedersen et al.(^{29})</td>
<td>82</td>
<td>Spine/SJ</td>
<td>Berlin</td>
<td>0.46/0.31</td>
<td>–0.41</td>
<td>–0.31</td>
<td>NS</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Puhakka et al.(^{81})</td>
<td>34</td>
<td>SJ</td>
<td>BME</td>
<td>–</td>
<td>NS</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rudwaleit et al.(^{73})</td>
<td>62</td>
<td>Spine/SJ</td>
<td>Berlin</td>
<td>–</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Steeper et al.(^{74})</td>
<td>20</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>0.5</td>
<td>NS</td>
<td>NS</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Song et al.(^{45})</td>
<td>76</td>
<td>Spine/SJ</td>
<td>ASsMRI-a/Berlin</td>
<td>p=0.04</td>
<td>–</td>
<td>NS</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visvanathan et al.(^{77})</td>
<td>279</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>–</td>
<td>NS</td>
<td>p&lt;0.001</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-sectional/case-control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blachier 2013(^{53})</td>
<td>648</td>
<td>Spine/SJ</td>
<td>Dichotomous</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>aOR 1.71–2.86</td>
<td></td>
</tr>
<tr>
<td>Goh et al.(^{65})</td>
<td>34</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>–</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Kitza et al.(^{86})</td>
<td>100</td>
<td>Spine</td>
<td>Berlin</td>
<td>NS</td>
<td>NS</td>
<td>0.22</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Konca et al.(^{60})</td>
<td>50</td>
<td>Spine</td>
<td>ASsMRI-a</td>
<td>0.37 NS</td>
<td>NS</td>
<td>0.33</td>
<td>0.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puhakka et al.(^{50})</td>
<td>41</td>
<td>SJ</td>
<td>BME enhancement</td>
<td>–</td>
<td>NS</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
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<tr>
<td>Weber et al.(^{49})</td>
<td>197</td>
<td>ACW</td>
<td>Dichotomous</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.21–0.33</td>
<td></td>
</tr>
</tbody>
</table>

The Spearman test for rank correlation is used for test of correlation, values are correlation coefficients (rho), if not otherwise indicated. \(p\) values indicate the level of statistical significance.

aOR, adjusted odd ratio; ACW, anterior chest wall; AS, ankylosing spondylitis; ASDAS, Ankylosing Spondylitis Disease Activity Score; ASsMRI-a/c, ankylosing spondylitis spine MRI score for activity; ASDAI, Bath Ankylosing Spondylitis Disease Activity Score; BME, bone marrow oedema; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; LEEDS, Leeds MRI scoring system; mNY, modified New York; MRI, magnetic resonance imaging; No., number of individuals included in the study; NS, not statistically significant; OR, odds ratio; RCT, randomised controlled trial; SJ, sacroiliac joints; SPARCC, Spondyloarthritis Research Consortium of Canada Scoring System; –, not done.

Four longitudinal\textsuperscript{106–109} and a single cross-sectional\textsuperscript{110} study evaluated the utility of MRI in monitoring disease activity in pSpA with three longitudinal studies reporting the psoriatic arthritis MRI score (PsAMRIS) and rheumatoid arthritis MRI score performing well regarding SE to change.\textsuperscript{106–108} Tan et al found no correlation between BME (as scored by PsAMRIS) and clinical disease activity measures in a cross-sectional study.\textsuperscript{110} There is currently no evidence whether and if so how frequently US and/or MRI should be repeated for the monitoring of disease activity in peripheral SpA. Quality assessment is reported in online supplementary figure S6.5; of note patient selection bias was high in 47\% of included manuscripts.

**Recommendation 6: monitoring structural changes in peripheral SpA**

In peripheral SpA, if the clinical scenario requires monitoring of structural damage, then conventional radiography is recommended. MRI and/or US might provide additional information.

**Strength of recommendation: 8.9 (95\% CI 8.4 to 9.4)**

Seven studies evaluated the utility of conventional radiography (CR) to monitor structural changes in pSpA,\textsuperscript{101 102 111–115} with one study also evaluating PDUs\textsuperscript{102} and an additional study evaluating MRI.\textsuperscript{110} Among the studies assessing the utility of radiography, two reported correlation with the functional indices Health Assessment Questionnaire and/or Ankyritis Impact Measurement Scales.\textsuperscript{114 115} A longitudinal study on 74 patients with PaSa reported correlation between clinical joint deformity, typical radiographic changes in PaSa and the PaSA-modified Sharp score.\textsuperscript{114} A case–control study on 98 patients with ReA reported correlation between radiographic condylar erosions of the temporomandibular joint and patient-reported outcomes.\textsuperscript{112} A cross-sectional study on 60 patients with AS reported correlation between BASFI and both radiographic and sonographic signs of enthesitis,\textsuperscript{102} while a cross-sectional study on 44 patients with SpA reported correlation between the SpA tarsal radiographic index and the Glasgow Ultrasound Enthesitis Score, but no correlation between the radiographic index and BASMI or BASRI.\textsuperscript{103} Finally, Tan et al\textsuperscript{110} reported correlation between MRI erosions/BME and CR erosions/joint space narrowing in 28 patients with PsA. Quality assessment is reported in online supplementary figure S6.6; of note risk of patient selection bias was high in 50\% of included manuscripts. There is currently no evidence whether and if so how frequently US and/or MRI should be repeated for the monitoring of structural changes in peripheral SpA.

**Recommendation 7: predicting outcome/severity in axial SpA**

In patients with AS* (not non-radiographic axial SpA), initial conventional radiography of the lumbar and cervical spine is recommended to detect syndesmophytes, which are predictive of development of new syndesmophytes. MRI (vertebral corner evidence whether and if so how frequently US and/or MRI should be repeated for the monitoring of structural changes in peripheral SpA. **Recommendation 7: predicting outcome/severity in axial SpA**

In patients with AS* (not non-radiographic axial SpA), initial conventional radiography of the lumbar and cervical spine is recommended to detect syndesmophytes, which are predictive of development of new syndesmophytes. MRI (vertebral corner

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### Table 4  Recommendation 4: summary of studies on the use of radiography in monitoring structural changes in axial spondyloarthritis

<table>
<thead>
<tr>
<th>Studies</th>
<th>No.</th>
<th>Region</th>
<th>X-ray scoring method</th>
<th>BASFI</th>
<th>BASMI</th>
<th>Correlation</th>
<th>CT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longitudinal/RCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machado et al\textsuperscript{113}</td>
<td>214</td>
<td>Spine</td>
<td>mSASSS</td>
<td>0.18; p=0.008 0.59; p&lt;0.001</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Lee et al\textsuperscript{116}</td>
<td>39</td>
<td>Spine</td>
<td>BASRI</td>
<td>0.47; p&lt;0.001</td>
<td>0.49, p&lt;0.001 (CR)</td>
<td>0.53–0.73 (p&lt;0.001)</td>
<td>–</td>
</tr>
<tr>
<td>Lubrano et al\textsuperscript{117}</td>
<td>77</td>
<td>Spine</td>
<td>mSASSS</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td></td>
</tr>
</tbody>
</table>

**Table 4** Recommendation 4: summary of studies on the use of radiography in monitoring structural changes in axial spondyloarthritis

**Correlation**

- **BASFI**: Bath Ankylosing Spondylitis Functional Index
- **BASMI**: Bath Ankylosing Spondylitis Metrology Index
- **BASRI**: Bath Ankylosing Spondylitis Functional Radiology Index
- **CE**: chest expansion
- **CR**: cervical rotation
- **FFD**: finger-to-floor distance
- **mSASSS**: modified Stoke Ankylosing Spondylitis Score
- **mSchober**: modified Schober’s test
- **NS**: not statistically significant
- **OWD**: occiput-wall distance
- **SF**: spinal flexion
- **SASSS**: Stoke Ankylosing Spondylitis Score
- **Schober**: Schober’s test
- **SII**: sacroiliac joints
- **TWD**: tragus-to-wall distance
- **Total spinal movement**

The Spearman test for rank correlation is used for test of correlation, values are correlation coefficients (rho), if not otherwise indicated. \( p \) Values indicate the level of statistical significance.

*That is, radiographic axial spondyloarthritis.

**Strength of recommendation: 9.0 (95\% CI 8.5 to 9.5)**

Seventeen publications were included.\textsuperscript{119 81 92 116–129} All studies evaluating radiography reported that baseline radiographic change (syndesmophytes) predicts radiographic progression in AS.\textsuperscript{116 118 122 126 129} Baraliakos et al reported that syndesmophytes/ankylosis, rather than erosion or sclerosis, were the features most frequently showing progression in AS.\textsuperscript{116} Maksymowych et al\textsuperscript{122} found that high baseline mSASSS (cut-off of 10 units; OR 18.6) was an independent predictor of 2-year progression in AS.
Six studies reported correlation between CILs or vertebral edge inflammation on MRI and subsequent radiographic syndesmophyte formation in patients with AS. Madsen et al. reported correlation of baseline inflammation and subchondral fatty marrow deposition on MRI with radiographic progression in the SI joint of patients with AS.

In a 2-year longitudinal study, Pedersen et al. found that new syndesmophytes develop more frequently from vertebral corners where a CIL had completely resolved on follow-up, and that no single vertebral corner evolved into a new syndesmophyte. The study also showed that no single vertebral corner evolved into a new syndesmophyte. Overall, the study presented a significant relationship between the disappearance of inflammation and the appearance of fatty lesions in the spine of patients with axSpA. Moreover, Baraliakos et al. showed that both spinal inflammation and fatty degeneration were associated with later syndesmophyte development, but fatty degeneration showed the highest risk in AS. In contrast, a retrospective analysis of 100 patients with AS, inflammation (OR 5.8) emerged as a more significant predictor of new syndesmophytes than did fat infiltration (OR 1.9). Finally, Bennett et al. reported no association between baseline BME on lumbar spine MRI and msSASSS progression after 8 years in patients with AS.

Avers et al. reported correlation between baseline QSS values and radiographic progression in the spine at follow-up (median: 9 years) in patients with AS. Quality assessment is reported in online supplementary figure S6.7.

**Recommendation 8: predicting treatment effect in axial SpA**

Extensive MRI inflammatory activity (BME), particularly in the spine in patients with AS, might be used as a predictor of good clinical response to anti-TNF-alpha treatment in axial SpA. Thus, MRI might aid in the decision of initiating anti-TNF-alpha therapy, in addition to clinical examination and CRP.

Strength of recommendation: 8.9 (95% CI 8.3 to 9.5)

A total of three studies were included. A longitudinal study of 62 patients with AS under treatment anti-TNF-alpha biologics reported a positive likelihood ratio of 6.7 for achieving BASDAI50 response in patients with a Berlin MRI spine score >11, while the absence of active inflammatory lesions in the spine was highly predictive of not achieving BASDAI50. Only a trend was found for the MRI SI joint score. An RCT of 185 patients with non-radiographic axial SpA reported that a baseline SPARC MRI score ≥2 for either the SI joint or the spine was associated with better response after 12 weeks of adalimumab. An RCT including 40 human leucocyte antigen B27 (HLAB27)-positive patients with MRI sacroiliitis found no significant difference in BASDAI changes between patients with mild versus moderate/severe MRI SI joint BME at baseline. Quality assessment is reported in online supplementary figure S6.8; of note risk of patient selection bias, as well as of flow and timing and applicability concerns, was each high in 33% of included manuscripts.

**Recommendation 9: spinal fracture**

When spinal fracture in axial SpA is suspected, conventional radiography is the recommended initial imaging method. If conventional radiography is negative, CT should be performed. MRI is an additional imaging method to CT, which can also provide information on soft tissue lesions.

Strength of recommendation: 9.3 (95% CI 8.9 to 9.7)

Although no study met the inclusion criteria for this recommendation, two studies selected for full-text review were presented to the taskforce as they could provide some evidence (quality assessment however was not performed). The first study included 11 patients with AS and neurological symptoms after trauma to the neck region. CT and MRI detected all fractures while radiography detected 82% of them. Soft tissue injuries were detected in four patients, only by MRI. The second study included 199 patients from the general population with suspected cervical spine injury. Twenty-one acute fractures were detected in 14 patients. Weighted average SE to detect acute fractures for MRI and radiography were 0.43 (95% CI 0.21 to 0.66) and 0.48 (95% CI 0.30 to 0.65), respectively. In contrast, weighted average SE to detect soft tissue injuries for MRI and radiography were 0.55 (95% CI 0.39 to 0.70) and 0.07 (95% CI 0.02 to 0.13), respectively. In addition to its utility in imaging soft tissue, MRI allows the direct visualisation of the spinal cord and thus direct evaluation of spinal cord injuries.

**Recommendation 10: osteoporosis**

In patients with axial SpA without syndesmophytes in the lumbar spine on conventional radiography, osteoporosis should be assessed by hip DXA and anterior–posterior (AP)-spine DXA. In patients with syndesmophytes in the lumbar spine on conventional radiography, osteoporosis should be assessed by hip DXA, supplemented by either spine DXA in lateral projection or possibly quantitative CT (QCT) of the spine.

Strength of recommendation: 9.4 (95% CI 9.0 to 9.8)

A total of 42 studies were included, while one additional study that did not meet the inclusion criteria but provided some evidence was also shown to the taskforce. Only one study compared the diagnostic utility between two different techniques for detecting osteoporosis in SpA. This reported moderate SE (0.50–0.75) and SP (0.67–0.75) for quantitative US compared with DXA. Three studies reported no addition value of quantitative US compared with DXA while three studies compared QCT to DXA and reported that in patients with advanced AS osteoporosis is more frequently detected by QCT of the spine than using DXA of the spine or the hip region.

Moreover, 37 studies (32 in axSpA and 6 in PsA) provided data on the site for performing DXA. Fifteen of these studies compared the AP/posterior–anterior (PA-)spine projection at the spine versus the hip region but the results were inconsistent: six studies observed no differences, eight reported results in favour of the hip, and one in favour of the spine. Three studies compared the AP/PA versus the lateral projection at the spine and all reported that the lateral projection differentiated better between AS and controls. Only four studies compared forearm DXA with other regions, all of them reporting data in favour of spine or hip and one in favour of the hip.

Furthermore, some studies also evaluated the possible influence of radiographic change, disease duration or disease activity in bone mineral density (BMD) determination at different regions. Most of the studies found the hip region being less influenced by radiographic change than the AP/PA projection of the spine. Two studies reported the lateral spine projection being less influenced by radiographic change than the AP/PA projection of the spine while no correlation was found with the lateral projection or at hip. However, most of the studies did not observe...
**Table 5** Recommendation 10: summary of studies evaluating different localisations to perform dual-energy X-ray absorptiometry in patients with axial spondyloarthritis

<table>
<thead>
<tr>
<th>Study</th>
<th>Radiographic damage (syndesmophytes/BASRI spine)</th>
<th>Results in favour of</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=11</td>
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<td></td>
</tr>
<tr>
<td>No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devogelaer et al 2007</td>
<td>70</td>
<td>X</td>
</tr>
<tr>
<td>Karberg 2005</td>
<td>59</td>
<td>X</td>
</tr>
<tr>
<td>Jun 2006</td>
<td>68</td>
<td>ND</td>
</tr>
<tr>
<td>Mullaji 1994</td>
<td>33</td>
<td>X</td>
</tr>
<tr>
<td>Gilg 2005</td>
<td>20</td>
<td>X</td>
</tr>
<tr>
<td>Muntean 2011</td>
<td>44</td>
<td>X</td>
</tr>
<tr>
<td>Taylor 2012</td>
<td>55</td>
<td>X</td>
</tr>
<tr>
<td>Vasdev 2001</td>
<td>80</td>
<td>ND</td>
</tr>
<tr>
<td>Baek 2005</td>
<td>76</td>
<td>X</td>
</tr>
<tr>
<td>Capaci 2003</td>
<td>73</td>
<td>X</td>
</tr>
<tr>
<td>Donnelly 1994</td>
<td>87</td>
<td>X</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gilg 2005</td>
<td>20</td>
<td>X</td>
</tr>
<tr>
<td>Klingberg 2012</td>
<td>204</td>
<td>X</td>
</tr>
<tr>
<td>(B)</td>
<td>Disease duration Correlation between BMD and disease duration</td>
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</tr>
<tr>
<td>Study</td>
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<td></td>
</tr>
<tr>
<td>No.</td>
<td></td>
<td></td>
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<tr>
<td>Arends 2011</td>
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</tr>
<tr>
<td>El Magahroui 1999</td>
<td>80</td>
<td>r=0.23</td>
</tr>
<tr>
<td>Gilg 2005</td>
<td>20</td>
<td>r=0.52</td>
</tr>
<tr>
<td>Grazio 2012</td>
<td>80</td>
<td>r=0.05</td>
</tr>
<tr>
<td>Jansen et al 2000</td>
<td>50</td>
<td>No</td>
</tr>
<tr>
<td>Meirelles 1999</td>
<td>30</td>
<td>r=0.65</td>
</tr>
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<td>Memerci 2010</td>
<td>100</td>
<td>r=0.25</td>
</tr>
<tr>
<td>Muntean 2011</td>
<td>44</td>
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<tr>
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<td>Slater 2012</td>
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<tr>
<td>van der Weijden 2013</td>
<td>130</td>
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<tr>
<td>Vasdev 2011</td>
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<td>Gilg 2005</td>
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<tr>
<td>Memerci 2010</td>
<td>100</td>
<td>r=0.25</td>
</tr>
<tr>
<td>(C)</td>
<td>Disease activity Correlation between BMD and disease activity parameters (ASDAS, BASDAI, CRP, ESR)</td>
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</tr>
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<td>Study</td>
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<td>Frediani et al 2014</td>
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<td>Grazio 2012</td>
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<td>Mullaji 1994</td>
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<td>44</td>
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<tr>
<td>Park 2008</td>
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<td>NS</td>
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<tr>
<td>Taylor 2012</td>
<td>55</td>
<td>NS</td>
</tr>
<tr>
<td>van der Weijden 2013</td>
<td>130</td>
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</tr>
<tr>
<td>Vasdev 2011</td>
<td>80</td>
<td>NS</td>
</tr>
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<tr>
<td>Memerci 2010</td>
<td>100</td>
<td>r=0.24</td>
</tr>
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</table>

The Pearson test for rank correlation is used for test of correlation, values are correlation coefficients (r). AP, anterior–posterior; ASDAS, Ankylosing Spondylitis Disease Activity Score; BASDAI, Bath Ankylosing Spondylitis Disease Activity Score; BASRI, Bath Ankylosing Spondylitis Radiology Index; BMD, bone mineral density; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; ND, no statistically significant differences; NS, not statistically significant; PA, posterior–anterior.

Correlation with AP/PA projection of the spine or at hip 135 141 146–148 151 158–160. In patients with PsA, published data are scarce. Three studies compared the ability of AP/PA DXA of the spine with DXA of the hip to distinguish between patients with PsA and controls but the results were not consistent.134 161 162. In patients with PsA, no correlation was observed between BMD detected by AP/PA DXA of the spine or the hip with disease duration134 163 or with disease activity.134 164

**Box 1 Future research agenda**

1. To further investigate which imaging findings (imaging modality, anatomical location and type of pathology) provides the best clinical utility for early and accurate diagnosis of SpA.
2. To further investigate which imaging findings (imaging modality, anatomical location and type of pathology) are best for monitoring peripheral and axial disease activity and structural damage in SpA in clinical practice.
3. To further investigate which imaging findings (imaging modality, anatomical location and type of pathology) best predict the disease course (structural progression, pain, functional ability, health-related quality of life) and treatment response in SpA.
4. To further investigate which imaging approaches best identify and monitor specific SpA-related features (such as enthesitis, dactylitis, synovitis and tenosynovitis, at different locations) in clinical practice.
5. To further investigate the spatial and temporal relation between different imaging findings (imaging modality, anatomical location and type of pathology) providing further insight into the disease process of SpA, which may inform future clinical management of SpA.
6. To investigate the importance of subclinical (detected only on imaging) axial and peripheral inflammation (including bone marrow oedema, synovitis, tenosynovitis and/or enthesitis), and if possible to identify thresholds to guide intervention. Subsequently to investigate the benefits (eg, on functional ability and quality of life) of incorporating such thresholds into treat-to-target strategies.
7. To investigate new and/or alternative technical options to existing imaging technologies (US: eg, 3D/4D-transducers, Doppler quantification, elastasonography; MRI: eg, whole-body MRI, diffusion-weighted MRI and dynamic contrast-enhanced MRI with automated reading) as well as new imaging modalities (eg, optical imaging, new nuclear medicine techniques) of potential use in SpA in clinical practice.
8. To further evaluate specific areas/joints to be assessed, timing of assessment(s) and the evaluation system to be employed in order to optimise the role of modern imaging modalities in the diagnosis, prognosis and outcome measurement of SpA.
9. To investigate which imaging approach provides the best clinical utility for early and accurate diagnosis of SpA.
10. To investigate which imaging approach provides the best clinical utility for diagnosis and monitoring of osteoporosis in SpA.
SpA, spondyloarthritits; US, ultrasound; 3D, three-dimensional; 4D, four-dimensional.
Finally, only four longitudinal studies assessed BMD over time to monitor osteoporosis in patients with SpA.\textsuperscript{1,65–168} In these studies, changes in BMD were observed after 1–2 years, especially in patients with active disease. Quality assessment is reported in online supplementary figure S6.9; of note risk of index test and reference standard bias were high in 86% and 88% of included manuscripts, respectively.

DISCUSSION

These are the first recommendations produced by a EULAR taskforce on the use of imaging in SpA clinical practice. The group combined research-based evidence and expert opinion through a translational process among the experts from the presented literature-derived evidence to the final wording. Recommendations were primarily based on available research evidence with the exception of recommendation 9, which, lacking available data, was reliant on expert opinion. Finally, experts scored the SOR for each recommendation using data from the quality assessment.

We acknowledge that there is still a large amount of research required to optimise the use of imaging tools in the routine clinical practice of SpA.\textsuperscript{176} We have summarised the most important topics for future research according to currently available evidence and clinical practice in box 1. These recommendations will likely need to be revisited in the future when important new evidence becomes available.\textsuperscript{12}

In summary, we have developed 10 recommendations on various aspects of imaging in SpA. These are based on the best available evidence and clinical expertise supported by an international panel of experts. We aimed to produce recommendations that are practical and valuable in daily practice for rheumatologists, radiologists and general practitioners.

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Contributors PM and VN-C performed the literature review with help from ST, PA and PAB. PM and VN-C produced drafts of the manuscript with advice from OM and LT. All authors were involved in the conception of the study, in the analysis and interpretation of data, in the production of the recommendations and have reviewed the final manuscript.

Competing interests PM: consultancy/speaker fees: AbbVie, BMS, GE, Janssen, MSD, Pfizer, Roche, UCB; VN-C: consultancy/research grants: AbbVie, BMS, MSD, Novartis, Pfizer, Roche, UCB; LT: consultancy/speaker fees: AbbVie, GE, MSD, Roche, UCB; PA: none; DvH: consultancy/research grants: AbbVie, Amgen, AstraZeneca, Augurex, BMS, Boehringer Ingelheim, Celgene, Centocor, Chugai, Covagen, Daichii, Eli-Lilly, Galapagos, GSK, Janssen Biologics, Merck, Novartis, Novo-Nordisk, Otsuka, Pfizer, Roche, Sanofi-Aventis, UCB, Vertex, Director of Imaging Rheumatology International; MADA: consultancy/speaker fees: AbbVie, BMS, MSD, Novartis, Pfizer, UCB; XB: consultancy/speaker fees: AbbVie, Amgen, Boehringer Ingelheim, BMS, Celgene, Centocor, Chugai, Janssen, MSD, Novartis, Pfizer, Sanofi, UCB; SJ: consultancy/speaker fees: AbbVie, MSD, Pfizer, Roche, UCB, Wyeth; research grants: AbbVie, MSD, AGI: none; EN: research grants: MSD, Spanish Foundation of Rheumatology; speaker fees: AbbVie, BMS, ESAOTE, GE, Pfizer, Roche, UCB; CS-W: speaker fees: AbbVie, Eli-Lilly, Roche, UU; speaker fees: AbbVie, MSD; MCW: none; PACB: none; EF: speaker fees: AbbVie, BMS, MSD, UCB; PGC: consultancy/speaker fees: AbbVie; BMS, BMS, Janssen, Merck, Novartis, Pfizer, Roche; MR: consultancy: AbbVie, BMS; speaker fees: Chugai, MSD, Novartis, Pfizer, Roche, UCB; GS: none; JS: consultancy/speaker fees: Abbott, Janssen, Merck, Lilly, Novartis, Roche; research grants: Abbott, Merck, Pfizer, SI: speaker fees: AstraZeneca, Norpharma, Pfizer; research grants paid to institute: AbbVie, BMS, Mundipharma, Roche, HM-O: speaker fees/research grants: AbbVie, Celgene, Janssen, MSD, Novartis, Pfizer, UCB; MÖ: research grant: AbbVie, Janssen, Merck; consultancy/speaker fees: AbbVie, BMS, Boehringer Ingelheim, Celgene, Centocor, Eli-Lilly, GSK, Hospira, Janssen, Merck, Mundipharma, Novartis, Orion, Pfizer, Roche, Takeda, UCB.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES


Madsen KB, Engud N, Jurik AG. Grading of inflammatory disease activity in the sacroiliac joints with magnetic resonance imaging: comparison between short-tau...


SUPPLEMENTARY MATERIAL

S1. Research questions (RQ)

Making a diagnosis of spondyloarthritis

RQ1- What is the diagnostic value of individual imaging modalities above clinical examination/criteria for axial SpA?

RQ2- What is the diagnostic value of individual imaging modalities above clinical examination/criteria for peripheral SpA (including peripheral psoriatic arthritis)?

Monitoring disease activity and structural damage in spondyloarthritis

RQ3- What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor disease activity in axial SpA?

RQ4- What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor structural changes in axial SpA?

RQ5- What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor disease activity in peripheral SpA (including peripheral psoriatic arthritis)?

RQ6- What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor structural changes in peripheral SpA (including peripheral psoriatic arthritis)?

Predicting outcome (severity) and treatment response

RQ7- What is the ability, and added value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict outcome (severity) in axial SpA?

RQ8- What is the ability and value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict treatment response in axial SpA?

RQ9- What is the ability, and added value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict outcome (severity) in peripheral SpA?

RQ10- What is the diagnostic value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict treatment response in peripheral SpA?

Making a diagnosis of spinal fracture or osteoporosis in spondyloarthritis
RQ11- What is the diagnostic value of individual imaging modalities above other imaging modalities for spinal fractures in SpA?

RQ12- What is the ability of individual imaging modalities to diagnose and monitor osteoporosis in SpA?

S2. Details of search strategy performed using MEDLINE via Pubmed (1948 to January 2013) and EMBASE via Ovid (1980 to January 2013).

RQ1-10

Search strategy, MEDLINE via Pubmed

1. "spondylarthropathies"[MeSH Terms]
2. spondylart*[Text Word]
3. (Reactiv*[TI] AND Arthriti*[TI])
4. (Psoria*[TI] AND Arthriti*[TI])
5. (ankyl*[TI] AND Spondyl*[TI])
6. (((inflam*[TIAB] OR peripher*[TIAB] OR tendon*[TIAB] OR tendinop*[TIAB] OR limb*[TIAB]) AND pain [TIAB]))
7. spondylol*[TIAB]
8. (((inflam*[TIAB] AND (back*[TIAB] OR spin*[TIAB]) AND pain [TIAB])))
9. or/1-8
10."Tomography"[Mesh]
11."Magnetic Resonance Imaging"[Mesh]
12."Ultrasoundography"[Mesh]
13."Tomography, X-Ray Computed"[Mesh]
14."Positron-Emission Tomography and Computed Tomography"[Mesh]
15."Positron-Emission Tomography"[Mesh]
16."Tomography, Emission-Computed, Single-Photon"[Mesh]
17.("magnetic"[All Fields] AND "resonance"[All Fields] AND "imaging"[All Fields])
18."mri"[All Fields]
19.ultrasono*[TIAB]
20.echograph*[TIAB]
21."CT scan"*[TIAB]
22.tomograph*[TIAB]
23.scintigraph*[TIAB]
24.(PET[Title/Abstract]) AND tomog*[Title/Abstract])
25.(SPECT[Title/Abstract]) AND photon[Title/Abstract])
26.or/10-25
27.9 and 26
28.(animals[mh] NOT human[mh])
29.27 not 28
30.(("case report"*[TI]) OR (case reports[Publication Type]))
31.29 not 30
32.english[Language]
33.31 and 32
Search strategy, EMBASE via Ovid

1. (magnetic and resonance and imaging).mp.
2. magnetic resonance imaging.mp.
3. mri.mp.
4. Ultrasonography.mp. or exp echography/
5. magnetic resonance imaging.mp. or exp nuclear magnetic resonance imaging/
6. "ultrasono*".ti,ab.
7. Tomography, X-Ray Computed.mp. or exp computer assisted tomography/
8. "CT scan*".ti,ab.
9. "echograph*".ti,ab.
10. "tomograph*".ti,ab.
11. "scintigraph*".ti,ab.
12. Positron Emission Tomography.mp. or exp positron emission tomography/
13. (PET and tomog*).ti,ab.
14. Tomography, Emission-Computed, Single-Photon.mp. or exp single photon emission computer tomography/
15. (SPECT and photon).ti,ab.
16. or/1-15
17. exp ankylosing spondylitis/
18. exp psoriatic arthritis/
19. exp reactive arthritis/
20. exp spondyloarthropathy/
21. (inflam* and (peripher* or tendon* or tendinop* or limb*) and pain).ti,ab.
22. "spondylo*".ti,ab.
23. (inflam* and (back or spin*) and pain).ti,ab.
24. or/17-23
25. 16 and 24
26. limit 25 to (conference abstract or conference paper or "conference review" or letter or conference proceeding)
27. 25 not 26
28. limit 27 to (animals or animal studies)
29. limit 28 to human
30. 28 not 29
31. 27 not 30
32. "case report*".m_titl.
33. case study.m_titl.
34. case report/
35. or/28-30
36. 31 not 35
37. limit 36 to english language
RQ11

Search strategy, MEDLINE via Pubmed

1. "spondylarthropathies"[MeSH Terms]
2. spondylart*[Text Word]
3. (Reactiv*[TI] AND Arthritis*[TI])
4. (Psoria*[TI] AND Arthritis*[TI])
5. (anky*l*[TI] AND Spondyl*[TI])
6. (((inflam*[TIAB] AND (peripher*[TIAB] OR tendon*[TIAB] or tendinop*[TIAB] OR
    limb*[TIAB]) AND pain [TIAB ]))))
7. spondylo*[TIAB]
8. (((inflam*[TIAB] AND (back[TIAB] OR spin*[TIAB] AND pain [TIAB])))
9. or/1-8
10. "Tomography"[Mesh]
11. "Magnetic Resonance Imaging"[Mesh]
12. "Ultrasonography"[Mesh]
15. "Positron-Emission Tomography"[Mesh]
17. ("magnetic"[All Fields] AND "resonance"[All Fields] AND "imaging"[All Fields])
18. "mri"[All Fields]
19. ultrasono*[TIAB]
20. echograph*[TIAB]
21. "CT scan*"[TIAB]
22. tomograph*[TIAB]
23. scintigraph*[TIAB]
24. (PET[Title/Abstract]) AND tomog*[Title/Abstract])
25. (SPECT[Title/Abstract]) AND photon[Title/Abstract])
26. x*ray*
27. "Radiography"[Mesh]
28. or/10-27
29. "Fractures, Bone"[Mesh]
30. "Fractures, Spontaneous"[Mesh]
31. "Osteoporotic Fractures"[Mesh]
32. "Spinal Fractures"[Mesh])
33. fractur*
34. or/29-33
35. 9 and 28 and 34
36. (animals[mh] NOT human[mh])
37. 35 not 36
38. (("case report*" [TI]) OR (case reports[Publication Type])))
39. 37 not 38
40. english[Language]
41. 39 and 40
Search strategy, EMBASE via Ovid

1. (magnetic and resonance and imaging).mp.
2. magnetic resonance imaging.mp.
3. mri.mp.
4. Ultrasonography.mp. or exp echography/
5. magnetic resonance imaging.mp. or exp nuclear magnetic resonance imaging/
6. "ultrasono**".ti,ab.
7. Tomography, X-Ray Computed.mp. or exp computer assisted tomography/
8. "CT scan**".ti,ab.
9. "echograph**".ti,ab.
10. "tomograph**".ti,ab.
11. "scintigraph**".ti,ab.
12. Positron Emission Tomography.mp. or exp positron emission tomography/
13. (PET and tomog*).ti,ab.
14. Tomography, Emission-Computed, Single-Photon.mp. or exp single photon emission computer tomography/
15. (SPECT and photon).ti,ab.
16. exp radiography/
17. x*ray*.mp.
18. exp X ray/
19. or/1-18
20. exp fracture/
21. fractur*.mp.
22. or/20-21
23. exp ankylosing spondylitis/
24. exp psoriatic arthritis/
25. exp reactive arthritis/
26. exp spondyloarthropathy/
27. (inflam* and (peripher* or tendon* or tendinop* or limb*) and pain).ti,ab.
28. "spondylo*".ti,ab.
29. (inflam* and (back or spin*) and pain).ti,ab.
30. or/23-29
31. 19 and 22 and 30
32. limit 31 to (conference abstract or conference paper or "conference review" or letter or conference proceeding)
33. 31 not 32
34. limit 33 to (animals or animal studies)
35. limit 34 to human
36. 34 not 35
37. 33 not 36
38. "case report**".m_titl.
39. case study.m__titl.
40. case report/
41. or/38-40
42. 37 not 41
43. limit 42 to english language
RQ12

Search strategy, MEDLINE via Pubmed

1. "spondylarthropathies"[MeSH Terms]
2. spondylart*[Text Word]
3. (Reactiv*[TI] AND Arthritis*[TI])
4. (Psoria*[TI] AND Arthritis*[TI])
5. (anky1*[TI] AND Spondyl*[TI])
6. (((inflam*[TiAB] AND (peripher*[TIAB] OR tendon*[TIAB] or tendinop*[TIAB] OR
   limb*[TIAB]) AND pain [TIAB])))
7. spondylo*[TIAB]
8. (((inflam*[TiAB] AND (back[TIAB] OR spin*[TIAB]) AND pain [TIAB])))
9. or/1-8
10. "Tomography"[Mesh]
11. "Magnetic Resonance Imaging"[Mesh]
12. "Ultrasonography"[Mesh]
15. "Positron-Emission Tomography"[Mesh]
17. ("magnetic"[All Fields] AND "resonance"[All Fields] AND "imaging"[All Fields])
18. "mri"[All Fields]
19. ultrasono*[TIAB]
20. echograph*[TIAB]
21. "CT scan*[TIAB]
22. tomograph*[TIAB]
23. scintigraph*[TIAB]
24. (PET[Title/Abstract]) AND tomog*[Title/Abstract])
25. (SPECT[Title/Abstract]) AND photon[Title/Abstract])
26. x*ray*
27. "Radiography"[Mesh]
28. "Absorptiometry, Photon"[Mesh]
29. DEXA
30. (bone*[TIAB]) AND densit*[TIAB]
31. "Bone Density"[Mesh]
32. or/10-31
33. osteoporos*
34. "Osteoporosis"[Mesh]
35. "Bone Density"[Mesh]
36. ((bone*[TIAB]) AND (loss*[TIAB] OR densit*[TIAB] OR mass*[TIAB]))
37. or/33-36
38. 9 and 32 and 37
39. (animals[mh] NOT human[mh])
40. 38 not 39
41. ("case report*" [TI]) OR (case reports[Publication Type]))
42. 40 not 41
43. english[Language]
44. 42 and 43
Search strategy, EMBASE via Ovid

1. (magnetic and resonance and imaging).mp.
2. magnetic resonance imaging.mp.
3. mri.mp.
4. Ultrasonography.mp. or exp echography/
5. magnetic resonance imaging.mp. or exp nuclear magnetic resonance imaging/
6. "ultrasono*".ti,ab.
7. Tomography, X-Ray Computed.mp. or exp computer assisted tomography/
8. "CT scan*".ti,ab.
9. "echograph*".ti,ab.
10. "tomograph*".ti,ab.
11. "scintigraph*".ti,ab.
12. Positron Emission Tomography.mp. or exp positron emission tomography/
13. (PET and tomog*).ti,ab.
14. Tomography, Emission-Computed, Single-Photon.mp. or exp single photon emission computer tomography/
15. (SPECT and photon).ti,ab.
16. exp radiography/
17. x*ray*.mp.
18. exp X ray/
19. DEXA.mp. or exp dual energy X ray absorptiometry/
20. exp absorptiometry/ or exp photon absorptiometry/
21. (bone* and (loss* or densit* or mass*)).ti,ab.
22. Bone Density.mp. or exp bone density/
23. or/1-22
24. (bone* and (loss* or densit* or mass*)).ti,ab.
25. Bone Density.mp. or exp bone density/
26. exp osteoporosis/ or Osteoporosis.mp.
27. osteoporos*.mp
28. or/24-27
29. exp ankylosing spondylitis/
30. exp psoriatic arthritis/
31. exp reactive arthritis/
32. exp spondyloarthropathy/
33. (inflam* and (peripher* or tendon* or tendinop* or limb*) and pain).ti,ab.
34. "spondylo*".ti,ab.
35. (inflam* and (back or spin*) and pain).ti,ab.
36. or/29-35
37. 23 and 28 and 36
38. limit 37 to (conference abstract or conference paper or "conference review" or letter or conference proceeding)
39. 37 not 38
40. limit 39 to (animals or animal studies)
41. limit 40 to human
42. 40 not 41
43. 39 not 42
44. "case report*".m_titl.
45. case study.m_titl.
46. case report/
47. or/44-46
48. 43 not 47
49. limit 48 to english language
S3. Flowcharts showing the three separate literature searches of 7550 articles, from which 298 articles were selected for detailed review; 157 articles were included in the final analysis.
## S4. Number of included articles per research question

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Number of included articles</th>
</tr>
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<tr>
<td>RQ1 - What is the diagnostic value of individual imaging modalities above clinical examination/criteria for axial SpA?</td>
<td>25</td>
</tr>
<tr>
<td>RQ2 - What is the diagnostic value of individual imaging modalities above clinical examination/criteria for peripheral SpA (including peripheral psoriatic arthritis)?</td>
<td>9</td>
</tr>
<tr>
<td>RQ3 - What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor disease activity in axial SpA?</td>
<td>34</td>
</tr>
<tr>
<td>RQ4 - What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor structural changes in axial SpA?</td>
<td>23</td>
</tr>
<tr>
<td>RQ5 - What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor disease activity in peripheral SpA (including peripheral psoriatic arthritis)?</td>
<td>15</td>
</tr>
<tr>
<td>RQ6 - What is the ability, and added value above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) of individual imaging modalities to monitor structural changes in peripheral SpA (including peripheral psoriatic arthritis)?</td>
<td>8</td>
</tr>
<tr>
<td>RQ7 - What is the ability, and added value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict outcome (severity) in axial SpA?</td>
<td>17</td>
</tr>
<tr>
<td>RQ8 - What is the ability and value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict treatment response in axial SpA?</td>
<td>3</td>
</tr>
<tr>
<td>RQ9 - What is the ability, and added value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict outcome (severity) in peripheral SpA?</td>
<td>3</td>
</tr>
<tr>
<td>RQ10 - What is the diagnostic value of individual imaging modalities above other measures (e.g. clinical examination, PROs, CRP, other imaging modalities) to predict treatment response in peripheral SpA?</td>
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<td>RQ11 - What is the diagnostic value of individual imaging modalities above other imaging modalities for spinal fractures in SpA?</td>
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<td>RQ12 - What is the ability of individual imaging modalities to diagnose and monitor osteoporosis in SpA?</td>
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S5. Reference list of included articles per recommendation

**Recommendation 1: Diagnosing axial SpA**

A. In general, conventional radiography of the SI joints is recommended as the first imaging method to diagnose sacroiliitis as part of axial SpA. In certain cases, such as young patients and those with short symptom duration, MRI of the SI joints is an alternative first imaging method.

B. If the diagnosis of axial SpA cannot be established based on clinical features and conventional radiography, and axial SpA is still suspected, MRI of the SI joints is recommended. On MRI, both active inflammatory lesions (primarily bone marrow edema) and structural lesions (such as bone erosion, new bone formation, sclerosis and fat infiltration) should be considered. MRI of the spine is not generally recommended to diagnose axial SpA.

C. Imaging modalities other than conventional radiography and MRI are not generally recommended in the diagnosis of axial SpA.

*CT may provide additional information on structural damage if conventional radiography is negative and MRI cannot be performed. Scintigraphy and US are not recommended for diagnosis of sacroiliitis as part of axial SpA.


**Recommendation 2: Diagnosing peripheral SpA**

When peripheral SpA is suspected, US or MRI may be used to detect peripheral enthesitis, which may support the diagnosis of SpA. Furthermore, US or MRI might be used to detect peripheral arthritis, tenosynovitis and bursitis.


**Recommendation 3: Monitoring disease activity in axial SpA**

MRI of the SI-joints and/or the spine may be used to assess and monitor disease activity in axial SpA, providing additional information on top of clinical and biochemical assessments. The decision on when to repeat MRI depends on the clinical circumstances. In general, STIR sequences are sufficient to detect inflammation and the use of contrast medium is not needed.


**Recommendation 4. Monitoring structural changes in axial SpA**

Conventional radiography of the SI joints and/or spine may be used for long-term monitoring of structural damage, particularly new bone formation, in axial SpA. If performed, it should not be repeated more frequently than every 2nd year. MRI may provide additional information.


**Recommendation 5. Monitoring disease activity in peripheral SpA**

US and MRI may be used to monitor disease activity (particularly synovitis and enthesitis) in peripheral SpA, providing additional information on top of clinical and biochemical assessments. The decision on when to repeat US/MRI depends on the clinical circumstances. US with high-sensitivity colour or power Doppler is sufficient to detect inflammation and the use of US contrast medium is not needed.


**Recommendation 6. Monitoring structural changes in peripheral SpA**

In peripheral SpA, if the clinical scenario requires monitoring of structural damage, then conventional radiography is recommended. MRI and/or US might provide additional information.


**Recommendation 7. Predicting outcome/severity in axial SpA**

**In patients with ankylosing spondylitis* (not non-radiographic axial SpA), initial conventional radiography of the lumbar and cervical spine is recommended to detect syndesmophytes, which are predictive of development of new syndesmophytes.** MRI (vertebral corner inflammatory or fatty lesions) may also be used to predict development of new radiographic syndesmophytes.

*i.e. radiographic axial spondyloarthritis*


**Recommendation 8. Predicting treatment effect in axial SpA**

*Extensive MRI inflammatory activity (bone marrow edema), particularly in the spine in ankylosing spondylitis patients, might be used as a predictor of good clinical response to anti-TNF treatment in axial SpA. Thus, MRI might aid in the decision of initiating anti-TNF therapy, in addition to clinical examination and CRP.*


**Recommendation 9. Spinal fracture**

When spinal fracture in axial SpA is suspected, conventional radiography is the recommended initial imaging method. If conventional radiography is negative, CT should be performed. MRI is an additional imaging method to CT, which can also provide information on soft tissue lesions.

---

**Recommendation 10. Osteoporosis**

In axial SpA patients without syndesmophytes in the lumbar spine on conventional radiography, osteoporosis should be assessed by hip DXA and AP-spine DXA. In patients with syndesmophytes in the lumbar spine on conventional radiography, osteoporosis should be assessed by hip DXA, supplemented by either spine DXA in lateral projection or possibly QCT of the spine.


S6. Quality assessment of included studies for individual recommendations (R) with QUADAS-2

S6.1

R1

Risk of bias

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Applicability concerns

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R2

Risk of bias

Applicability concerns

PATIENT SELECTION

INDEX TEXT

REFERENCE STANDARD

FLOW AND TIMING

low unclear high

0% 20% 40% 60% 80% 100%
R3

Risk of bias

- Patient Selection: 23, 2, 9
- Index Text: 32, 2
- Reference Standard: 31, 3
- Flow and Timing: 31, 1, 2

Applicability concerns

- Patient Selection: 27, 2, 5
- Index Test: 32, 2
- Reference Standard: 30, 4

Legend: low, unclear, high
R6

Risk of bias

- **PATIENT SELECTION**
  - Low: 4
  - Unclear: 1
  - High: 3

- **INDEX TEXT**
  - Low: 6
  - High: 2

- **REFERENCE STANDARD**
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  - High: 2

- **FLOW AND TIMING**
  - Low: 7
  - High: 1

Applicability concerns

- **PATIENT SELECTION**
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  - Unclear: 1

- **INDEX TEST**
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  - High: 2

- **REFERENCE STANDARD**
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Legend:
- Low
- Unclear
- High
**Risk of bias**

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  - Unclear: 2
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- **FLOW AND TIMING**
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**Applicability concerns**

- **PATIENT SELECTION**
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- **INDEX TEST**
  - Low: 17

- **REFERENCE STANDARD**
  - Low: 17
EULAR recommendations for the use of imaging in spondyloarthritis

Imaging techniques are a key component of the classification of spondyloarthritis, allowing patients to be classified into distinct groups and to receive the appropriate treatment.

INTRODUCTION
Spondyloarthritis is an umbrella term for several conditions that share many of the same features and symptoms, including ankylosing spondylitis, psoriatic arthritis and reactive arthritis. Patients can also be classified as having axial or non-axial (peripheral) disease, according to which joints in their body are affected. Axial disease affects the sacroiliac joint (in the back part of the pelvis) causing back pain and stiffness. It can be difficult to diagnose and classify these different diseases as they can lack distinguishing symptoms, and may develop over a long period of time. Therefore, imaging techniques that allow doctors to see inside the joints can be useful. These techniques include X-ray, magnetic resonance imaging (MRI), computerised tomography (CT scan) and ultrasound.

WHAT DID THE AUTHORS HOPE TO FIND?
The authors hoped to gain a better understanding of the available literature and evidence supporting the use of various imaging techniques in spondyloarthritis in order to develop and publish recommendations for imaging in spondyloarthritis. The recommendations are intended to provide advice to doctors and patients, and to act as a measure of quality for treatment and management.

WHO WAS STUDIED?
The recommendations are based on data from patients diagnosed with either established or suspected axial or peripheral spondyloarthritis and patients with chronic, non-inflammatory back pain as well as those with other rheumatic diseases and healthy control subjects. All patients were over the age of 18.

HOW WAS THE STUDY CONDUCTED?
The basis of the recommendations was a systematic review, which aims to identify all the published evidence on a particular topic and draw it together into one summary. In this case a group of experts in spondyloarthritis, including both rheumatologists and radiologists, performed a systematic review on the role of imaging in diagnosis and monitoring, as well as its usefulness in predicting disease progression in spondyloarthritis. A total of 7550 references were identified, of which 158 were included in the final review. Based on the extracted evidence the experts drafted 10 recommendations for doctors to use.

WHAT WERE THE MAIN FINDINGS OF THE STUDY?
The authors developed 10 recommendations for the use of imaging in patients with spondyloarthritis.

1. **Axial spondyloarthritis: diagnosis**
   - Conventional radiography (X-ray) of the sacroiliac joints in the lower back is recommended as the first imaging method. In young patients and those who have not had their symptoms for long, MRI may be used instead, although MRI of the spine is not generally recommended for this.

2. **Peripheral spondyloarthritis: diagnosis**
   - Ultrasound or MRI may be used to detect symptoms of peripheral spondyloarthritis.

3. **Axial spondyloarthritis: monitoring activity**
   - MRI of the sacroiliac joints and/or spine may be used to assess and monitor disease activity. The regularity of MRI depends on the clinical circumstances for each patient.

4. **Axial spondyloarthritis: monitoring structural changes**
   - Conventional radiography of the sacroiliac joints and/or spine may be used to monitor structural damage and new bone formation. It should not be repeated more often than every 2 years, and MRI can be used in between if more information is needed.

5. **Peripheral spondyloarthritis: monitoring activity**
   - Ultrasound and MRI may be used to monitor disease activity, and certain types of ultrasound can also detect inflammation. How often this should be performed depends on each patient’s clinical circumstances.

6. **Peripheral spondyloarthritis: monitoring structural changes**
   - Conventional radiography is recommended, although MRI and/or ultrasound might provide additional information.

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7. Axial spondyloarthritis: predicting outcome/severity
   - In patients with ankylosing spondylitis (not non-radiographic axial spondylitis), initial conventional radiography of the lumbar and cervical spine is recommended; MRI may also be used.

8. Axial spondyloarthritis: predicting treatment effect
   - Extensive MRI inflammatory activity in the spine of patients with ankylosing spondylitis might be used as a predictor of good clinical response to certain treatments.

9. Spinal fracture
   - When spinal fracture in axial spondylitis is suspected, conventional radiography is the recommended initial imaging method. If conventional radiography is negative, a CT scan should be performed. MRI is an additional imaging method which can also provide information on soft tissue lesions.

10. Osteoporosis
    - Osteoporosis should be assessed in some patients with axial spondylitis by bone density scanning.

ARE THESE FINDINGS NEW?
Yes – these are the first recommendations from the European League Against Rheumatism (EULAR) that look at the entire spectrum of spondyloarthritis disease types and evaluate the role of all commonly used imaging techniques.

HOW RELIABLE ARE THE FINDINGS?
The authors are confident that the findings are reliable and that the recommendations can be used by doctors with their patients.

For certain research questions that the authors asked – such as those dealing with predicting disease or treatment response – the review revealed only very few studies, and thus the recommendations in this area are based more on expert opinion than is the case with other areas where more study information and data were available.

WHAT DO THE AUTHORS PLAN ON DOING WITH THIS INFORMATION?
The authors plan to make the recommendations available to both doctors and patients. It is EULAR policy to review and revise recommendations on a regular basis, so the process will be performed again to check for new data in 5 years.

WHAT DOES THIS MEAN FOR ME?
These recommendations provide important information about the use of imaging techniques, both in diagnosis and management, and in predicting how patients will respond to treatments, as well as monitoring how their disease may be progressing at a structural level, before any symptoms occur.

The information in these recommendations may enable you to influence how your disease is diagnosed by being aware of what imaging techniques are useful. Being aware of how imaging techniques are used may also help you to understand why it is important to attend regular monitoring appointments, even if you feel well. If you have any questions about imaging, you should talk to your doctor.

Disclaimer: This is a summary of a scientific article written by a medical professional (“the Original Article”). The Summary is written to assist non medically trained readers to understand general points of the Original Article. It should not be relied on in any way whatsoever, (which also means the Summary is not medical advice), and is simply supplied to aid a lay understanding of general points of the Original Article. It is supplied “as is” without any warranty. You should note that the Original Article (and Summary) may not be accurate as errors can occur and also may be out of date as medical science is constantly changing. It is very important that readers not rely on the content in the Summary and consult their medical professionals for all aspects of their health care. Do not use this Summary as medical advice even if the Summary is supplied to the reader by a medical professional. Please view our full Website Terms and Conditions.

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Summary based on research article published on: 2nd April 2015


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